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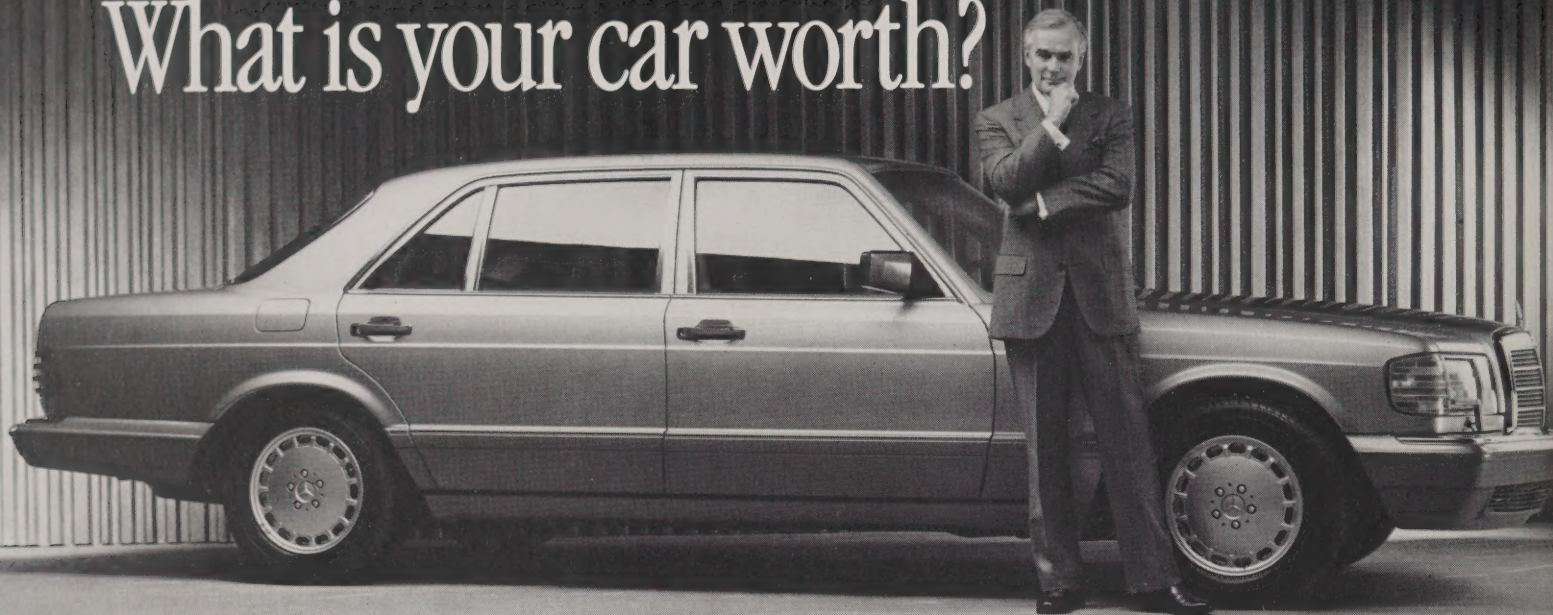
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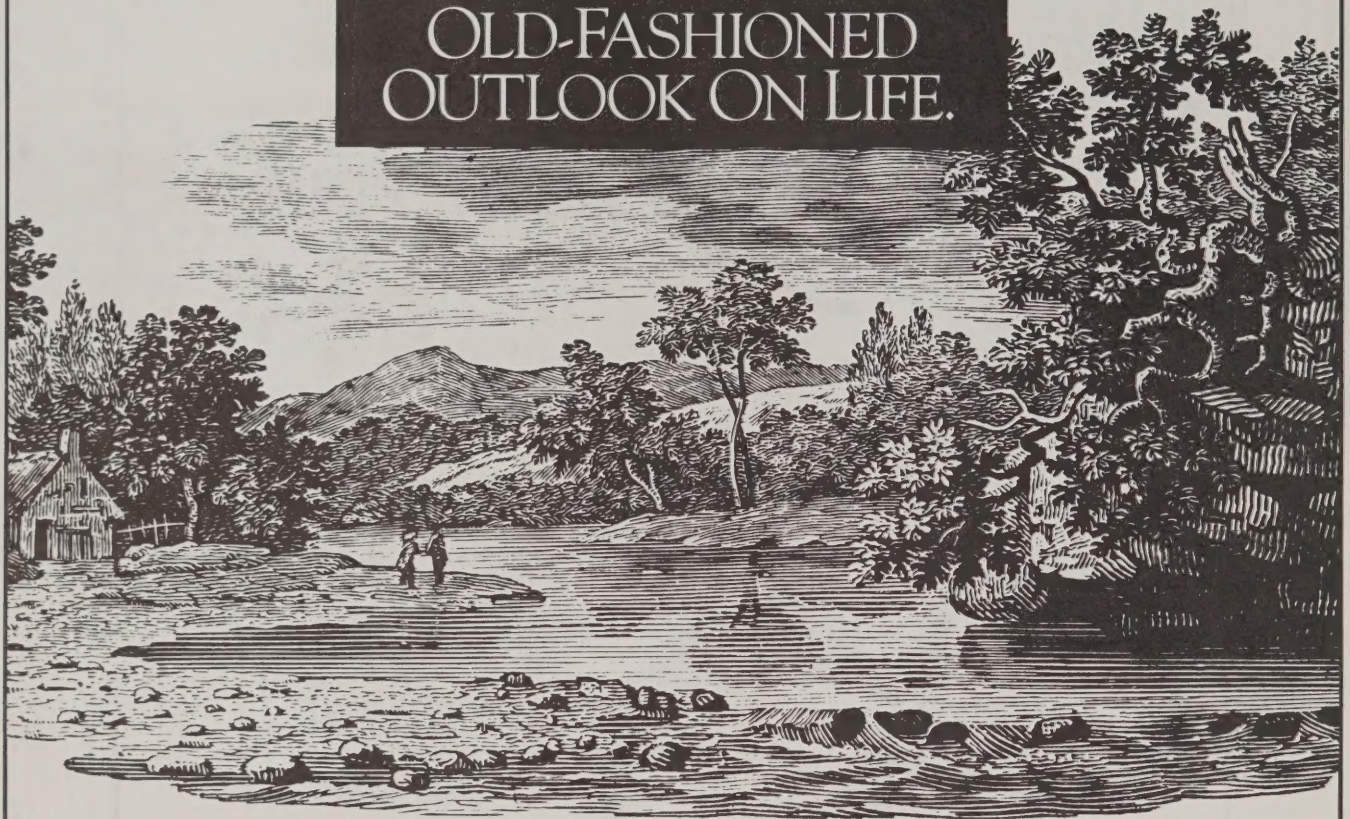
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**THE HAMPDEN HIPPOCRAT**

OCTOBER-NOVEMBER 1989
VOLUME XXXV NO. 5

IN THIS ISSUE

HDMS President's Message	6
Franklin Medical Center	8
Disability Insurance—Part 1	10
Committee Highlights	12
Fall District Meeting	14
Differing Views of our Health Care "Crisis"	17
Springfield Public Health Department Upgrade Report	19
Welcome New Members	21
Hampden District Medical Society Auxiliary Update	23
Welcome Kerin Milesky	25
A Labor Day Citation	25

On our cover is Franklin Medical Center in Greenfield, Massachusetts.
See related article on page 8 in this issue.

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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HDMS President's Message



Nancy L. Weiss, M.D., President

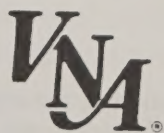
Two years ago, the Long Range Planning Committee extensively reviewed our society's goals and organization. They wrote a four page "white paper" in January, 1989 summarizing their recommendations. Many of these were implemented. Much of this report stressed putting the HDMS and its doctors before the public in a positive and outgoing way. This year, we will do this

in two ways. The first, an active public relations program and the second, moving the office.

The most ambitious activity is the expanded role for the public relations committee. We have put Michael Barnes, of Barnes and Barnes Advertising, on retainer to work only in this area. She has already helped with T.V. and newspaper coverage of our most recent meeting. In addition, our physicians will be before the public in many different ways, eg. on television and radio, speaking to local civic and church groups. We also plan to get to know our Legislator's better with legislative breakfasts and mini-internships (inviting Legislators' to spend a full day one-on-one following a physician on rounds and during office hours). Anyone with suggestions, please contact Carol Nystrom at the office or Dr. John Papale or Dr. Fred Garcia, Co-chairman of the PR Committee.

Another recommendation was "relocate the Society office to more accessible location." As I explained at the September 26th meeting, we may have to do this soon anyhow. Municipal Hospital wants back the space we use there. We can hardly argue since we pay no rent. I have appointed a committee to look into possible locations. I favor somewhere, not on a hospital campus, with easy access to Route 91 and good night time security. It must also allow easy public entrance. Right now with the changes at Municipal Hospital, the public can no longer walk into our office for information and help. Again, anyone with suggestions, call me.

The next six months should see HDMS more visible and in a new location and without a dues increase. ■



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Franklin Medical Center

This is the fifth in a continuing series of articles featuring Western Massachusetts Hospitals

When a medical institution succeeds within the current healthcare environment, it's to the credit of its entire community—medical and lay professionals, board members and volunteers, benefactors, and the people who rely upon its services. Franklin Medical Center in Greenfield is one example of an entire community dedicating its resources and creative energies to guarantee the availability of quality medical care.

Since its beginning in 1895, the medical center has taken pride in its wide range of services, developed partly in response to its communities' relative isolation.

What began as a 10-bed hospital located in a rented home has developed into a healthcare network that reaches throughout Franklin County and beyond. Its programs include a 24-hour emergency department, obstetrical and pediatric programs, an intensive care unit, inpatient and outpatient mental health services, rehabilitation, and substance abuse services.

Diagnostic capabilities such as nuclear medicine, CT scanning, ultrasound, and mammography, combined with other specialized programs have eliminated the need for many local residents to travel for high-quality care.

In 1985, Franklin Medical Center became a member of Baystate Health Systems. As a result, the advanced resources of Baystate Medical Center, a major research and teaching facility, have been made available through cooperative programming in kidney dialysis, oncology, and emergency medicine. Preferential referral arrangements between Franklin and Baystate medical centers have been created for those in need of tertiary care.

Corporate support from Baystate Health Systems has enabled Franklin Medical Center to attract new clinical and administrative talent and share resources in areas such as planning and marketing, management information systems, management engineering, finance, human resources, purchasing, and public affairs.

In similar fashion, various community programs, including Visiting Nurse and Health Services, Hospice in Franklin County, the Elder Day Center, Mercy Ambulance Service of Franklin County, and Mercy Chair Car Service of Franklin County, have joined with Franklin Medical Center in order to benefit from combined strengths and resources.

For the past two years, Franklin Medical Center has been deeply involved in an effort to renovate and revitalize its

facilities in response to a growing demand for its services.

"The growth of our services over the past 10 years, especially in outpatient areas, has used up our supply of available space and taxed our physical plant to the limit," said Harlan J. Smith, president and CEO. Ambulatory surgical cases have risen to over 2,000 each year. The emergency department responds to over 33,000 cases annually, more than triple the volume when the unit opened in the early 1970's.

Anticipating the need for expansion, the medical center's Board of Directors commissioned a space and facilities study in late 1987.

Merrill C. Raikes, M.D., a radiologist who serves on the medical center board, recalls, "Although it's considered itself a full-service facility, the Franklin mainly emphasized inpatient services. With the changes in reim-

bursements, utilization review, pre-admission testing, and all, there's been a change in the number of admissions and an increase in the number of outpatient and ancillary programs."

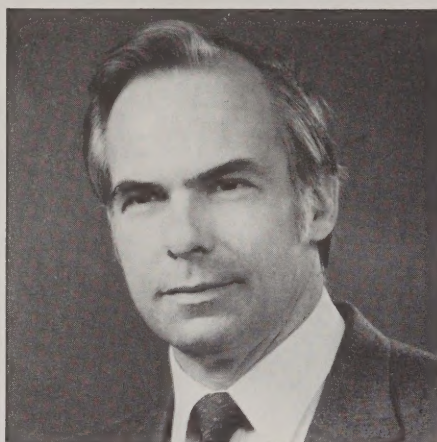
"At that time, the board recognized it was necessary to expand the outpatient and ancillary programs. That's when the major space study was undertaken to find out where we stood in relation to where the marketplace was going to be, not only from the standpoint of the hospital's financial survival, but also to deliver the service that the community was going to demand," he said.

The process, which was facilitated by a consultant, included a department-by-department study of existing facilities, the services each department delivered, and desired improvements in the level of care.

Thomas L. Dourmashkin, the emergency department's medical director, was involved in planning major revisions for his department, a major component of the revitalization plan.

"The entire staff provided a great deal of input into the planning process. Nurses added their feelings in terms of patient flow, and the doctors added a great deal of information that led to the planning of a self-contained trauma unit that will exist within the department," he said. He added that the new design also improves patient visibility and accessibility, thus enhancing the overall quality of care.

Raikes said that medical directors of services throughout the medical center provided similar input as part of a process.



William E. Callahan, M.D.,
President, Medical/Dental Staff

As a result of the study, the board approved a three-year revitalization plan designed both to expand facilities and improve access to the medical center.

The need for additional space became even more immediate in late 1988 following the curtailment of services at nearby Farren Memorial Hospital, which led to a 30% increase in the number of persons relying on Franklin Medical Center for services.

The current revitalization plan, expected to cost \$5.7 million, consists of building and renovation projects distributed throughout the medical center. In addition to the emergency department, the plan will provide additional space for physical and occupational therapy as well as ambulatory surgery. A one-story addition to the front of medical center will provide space for outpatient service, such as pre-admission testing, renal dialysis, oncology, endoscopy and minor procedures. The addition will also provide space for patient registration, gift and coffee shops, waiting areas, educational meeting rooms, and improved barrier-free access.

While preliminary work has begun, the bulk of the revitalization will begin this fall, with completion set for 1992.

From the very beginning, it was clear that such an ambitious effort would require significant community support. A capital fund-raising campaign, the most ambitious in the history of Franklin County, was begun this past spring. To date, the Building Our Future Capital Cam-

paign has raised \$2,130,000 in pledges, nearly \$1 million in excess of the original goal.

According to campaign leaders, the overwhelming success was partly the result of the \$875,000 pledged early in the campaign by medical center physicians, staff, auxiliaries, and Baystate Health Systems. The expression of support from within the medical center quickly spread to all corners of the community.

Local residents have demonstrated their intangible, as well as their tangible, support for Franklin Medical Center's services. The board of directors and the board of overseers include 580 local residents who insure that the medical center continue to reflect the value and needs of the public it serves. Over 750 volunteers provide thousands of hours of valuable service through the Board of Organized Work, the Junior Branch, the Red Cross, and the Volunteer Services Office. The 122 Medical/Dental Staff members provide additional expertise by serving on various committees that monitor patient-care issues.

The dedication of its community has created a medical center that has remained financially stable despite many economic uncertainties.

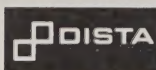
It's clear that the future holds significant challenges to the quality and availability of adequate healthcare. Through its medical center, the residents of the Franklin County area have provided many sound investments in their communities' well being. ■

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Disability Insurance—Part 1

Disability insurance is an important item for all physicians. This is particularly true for the solo practitioner or the member of a small group.

The purpose of disability insurance is to provide income during a period when the physician is unable to work due to sickness or injury.

There are two general types of disability insurances. One is designed to replace income for the physician. The second is office overhead insurance which is designed to cover office expenses while a physician is disabled.

There are two general sources of this insurance. Group insurance is available through organizations such as the Hampden District Medical Society, the Massachusetts Medical Society, AMA, etc. Individual policies are obtained via insurance agents with an individual policy being written by a major insurance company.

There are substantial variations among different insurance policies. It is important for the physician to understand these differences and also to be able to select insurance that best meets his or her needs.

Perhaps the most important single item is the definition of disability. Here, the policy will state the circumstances under which payments for disability will be made. The ideal situation is where an individual is disabled if he or she cannot perform his usual occupation. In the sense of a physician, this would apply to one's specialty—surgeon, ophthalmologist, emergency physician, etc. Some policies are written to cover the specific occupation for a period of time and then after that, any occupation. This type of policy is generally undesirable and should be avoided. Policies that pay benefits only when a person is unable to perform any job are particularly unsatisfactory.

Almost all disability programs have a waiting period between the time the individual becomes disabled and the time that payments start. The cost of the insurance is modified by this, the longer the waiting period, the less expensive the policy will be.

Similarly, the duration of disability payments also is variable. Some policies are written to cover an individual to a certain age, usually age 65. Others are written to

cover a specific time interval, 2-5-7½ years, etc. Recently some individual policies are written to cover the individual for life. The cost of the coverage will vary according to the duration of exposure to the insurance company.

One very important issue is the question of partial disability. Some policies will permit a partial payment during the period of time that a physician can return to work only on a limited basis. These are not common. In most instances, one is either totally disabled or not. In some cases, a so called return to work bonus is available where the physician receives a lump sum payment upon returning to work.

Coordination of benefits is an important issue. Some policies contain a provision reducing the payment by other income, specifically social security benefits in the case of a physician who becomes permanently disabled. In addition, other policies are written to reduce payments by the amounts the individual earns upon returning to work. This is particularly undesirable if an individual has multiple policies containing one of these provisions.

In general, individual policies require a physical examination while most group plans require a health statement with the possibility of a physician examination if there is a history of a serious illness or injury.

The tax consequences of disability benefits are also an important consideration. Currently, the benefits obtained where the individual paid for the premiums with after tax dollars, are not taxed. If the physician purchases disability insurance through his practice or professional corporation and uses the cost of the premiums as a tax deduction, then benefits are taxed as regular income.

In some instances, riders can be obtained where disability insurance will be issued, but will not be effective if the cause of the disability is a pre-existing problem. This type of insurance is generally more expensive but is extremely valuable to a physician with a health problem.

Another factor is the limits which a particular company will cover a physician. There are two aspects here.

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All companies have a dollar limit that they will write. In addition to this, most companies will only participate in a dollar amount or a percentage of income through all insurance. The individual, when applying for insurance, must state what other insurance is in force. In most cases, the latter limit is 60-70% of one's income. This limit can sometimes be exceeded by additional insurance obtained under special circumstances.

The permanency of disability insurance is also an important consideration. Most good individual insurance policies contain a so called "non-cancellable" provision. Here, the company is stating that the policy cannot be cancelled under any circumstances. The one exception to this, of course, would be the event of the issuing company going out of business. This is to avoid the situation where an individual who may develop a health problem that could become recurrent could have the policy cancelled because of this.

Many group programs will write the non-cancellable provision into their policies in the sense that the individual cannot be cancelled as long as the group is in force. Here the exposure is to the situation where the entire group may be cancelled. This has occurred in the past to physician organizations. Usually, a new carrier will replace the previous plan. The individual who develops a health problem in the interim, however, can be placed in a very difficult situation if all of his insurance coverage is through one group plan.

Office overhead insurance is written for the purpose of covering office expenses during a period of disability

when the individual is planning to return to work or under circumstances where he is permanently disabled and the office must continue operating until all of the business and obligations of the physician are completed.

This is usually of short duration. These policies are either written for specific amounts or geared to specific dollar expenses, i.e., rent, salaries, malpractice insurance, etc. This type of insurance is extremely important for solo practitioners and members of small groups in that these expenses continue for a considerable period of time following the onset of a disability.

The members of the Hampden District Medical Society have four potential sources of disability insurance available to them. We have non-exclusive endorsements of Lester Burdick, Inc., The Monarch Life Insurance, and The New England Life Insurance Company. The Lester Burdick Insurance is group insurance while the Monarch and New England plans offer individual insurance at a substantial discount.

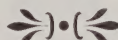
Group disability insurance is also available throughout the Mass Medical Society from the Kirk Van Orsdale organization.

This type of insurance is also available, of course, from other sources.

In the next issue of the Hippocrat, I will attempt to present a comparison of the various features of the four programs available to you. ■

Respectfully submitted
Lorne C. Smith, M.D., Insurance Chairman
Hampden District Medical Society

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Committee Highlights

During the summer months most of the committees have been inactive, except for the Executive Committee. The Executive Committee met on August 15, 1989. After discussion of the abuse of powers by the Board of Registration of Medicine and a letter from Dr. Keroack concerning a complaint about the American Red Cross, attention was directed to the beginning of the search for new office space for the District Medical Society.

The major item of business was a report from Dr. Smith of the Insurance Committee. Dr. Smith said the New England Insurance Company's disability plan is excellent and they are a sound company with a very good rating. New England Insurance has stated they are willing to accept any restrictions we might set up and will advertise in the Hampden Hippocrat. Dr. Smith suggested that the Executive Committee approve endorsing the New England Insurance in principle.

Plans for the District Meeting meeting in September and a report on the Physician Survey were then discussed.

Dr. Glackin had written expressing concern about the new rules regarding quality review of Medicare patients implemented by Mass Pro in July, 1989. Dr. Glackin asked that a resolution be written protesting the regulations. Dr. Slachta and Mrs. Nystrom will look into submitting the material for the October Council Meeting.

The next meeting of the Executive Committee was on September 19, 1989. The Hippocrat advertising policies were discussed and a motion was made and seconded that the Executive Committee supported the advertis-

ing policies of the co-editors of the Hippocrat.

It was announced that Dr. Donald Higby was joining the Hippocrat as a fourth co-editor.

Dr. Glackin's resolution regarding Mass Pro was submitted to the Mass Medical Society, but there was difficulty getting it on the agenda because the agenda was filled.

Final plans for the District Meeting in September were discussed.

There was an update on the search for new office space.

It was announced that there was a November 1st Mass Medical Society Risk Management Program at the Springfield Marriott. There are plans underway for another Risk Management Program in the Hampden area on March 6, 1990.

There was a review of the Public Relations Program. It was decided to have Barnes and Barnes Advertising give a three month plan of exposure on educational items to newspapers, T.V. and radio beginning October 1, 1989.

Dr. Weiss stated she discussed the plans for phasing out the Springfield Academy of Medicine library with Dr. Janovsky. Dr. Weiss stated that she and Dr. Papale and Dr. Slachta will be attending a dinner and tour of the new regional office of the Mass Medical Society in Northampton on October 25, 1989.

Dr. Slachta gave an in-depth Legislative Report and reviewed the MMS Executive Board Meeting held on September 13, 1989. ■

Terry D. Ryan, M.D.
Co-Editor

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Fall District Meeting

The Fall Meeting of the Hampden District Medical Society was held at Chez Joseph on September 26, 1989. Dr. Nancy Weiss called the meeting to order and read the minutes from the previous meeting which were approved.

Dr. Charles Cahill reviewed the current status of the Springfield 24 which is now reduced to 14 as 10 of the accused obstetricians have paid their fine and have agreed to join Blue Cross and Blue Shield or have retired. Dr. Cahill stated that the trust fund is now about half depleted by the first round of legal fees. Physicians who settle will receive no payments from the fund. Physicians who are fighting for our rights will receive monies from the fund after they have paid their first \$10,000 in legal fees. It is expected that in approximately nine months there will be a summary judgement by a judge as to whether there should be a trial.

Michael Kelly, Director of Government Relations for Mass. Medical Society, gave a Legislative Up-date. He stated that the legislature just returned from their summer recess and much of their time will be spent in the next few months on the state's fiscal crisis. He also stated that much of the time and effort on Beacon Hill will be spent on jockeying for positions by a large number of politicians who will be running for statewide offices in 1990.

He discussed the professional liability no-fault bill and said it will be filed again by Mass. Medical Society this year. Potential legislation concerning claims-made tails for retiring physicians and an infectious waste bill are two of the major items of Medical Society interest. The nurses prescription writing bill appears to be moving toward passage.

Dr. Carl Janovsky reported on the dismantling of the Springfield Academy of Medicine Library. He hopes it will be phased out by April, 1990. He stated that the Springfield Municipal Hospital is interested in keeping some of the books, particularly those relating to geriatrics, and is being very helpful. The remainder of the collection is being appraised, especially the historical books.

Mrs. Kerin L. Milesky spoke briefly. She is the new coordinator of the West Central Regional Office of the Mass. Medical Society. This new Regional Office which is opening October 1, 1989, at 98 Main Street in Northampton will be serving the membership of Worcester, Worcester North, Hampden, Hampshire, Berkshire, and Franklin Districts and will act as an extension of the Waltham Office.

Dr. Weiss then brought up for discussion a possible move of the Hampden District Medical Society Office. We now have approximately 1,000 square feet at the Springfield Municipal

Hospital Building. There is concern that the Springfield Municipal Hospital may want the space and our leadership has been unofficially looking for a place to move. They are interested in being near the Route 91 corridor, but not in a hospital campus and at a safer site than the current office is for evening meetings. Dr. Weiss asked for and received a motion to the effect that if the Hampden District Medical Society is evicted from their present office and needs to find new place quickly that the leadership will be allowed to do so if they can without increasing the dues. A few objections were voiced but the motion was then carried by a resounding majority.

Up-coming functions of the District Medical Society were announced. There will be the Fifth Annual Medical Ethics Seminar on October 25, 1989, 7:00 p.m. at the Deliso Center of Mercy Hospital. The next District Meeting will be January 23, 1990, at Sheraton West. Dr. C. John Tupper, President Elect of the AMA, will be our speaker.

After adjourning for social hour and dinner the meeting was continued with the featured speaker,

Representative Steven D. Pierce, the Minority Leader of the Massachusetts House of Representatives. Other members of the political establishment who were invited to meet with us at the dinner were Senator Brian Lees, Ms. Cynthia Tucker who is the legislative counsel representing Senator Linda Melconian, Representative and Mrs. Paul Caron, Representative and Mrs. Athan Catjakis, Representative Iris Holland and her husband Mr. Gilbert Holland, Representative and Mrs. Raymond Jordan, Representative and Mrs. Anthony Scibelli, and Representative Michael Walsh.

Representative Steven Pierce represents the city of Westfield and the town of Montgomery. He was first elected State Representative in 1978 and has served his district since that time. Last July Mr. Pierce was named Legislator of the Year by National Republican Legislature Association from among 3,000 state senators and representatives. He has been a leader in House debates over the state's budget and has been a leading advocate of stronger management of the Commonwealth's finances. He is a graduate of Union College and Duke University School of Law.

continued



Kerin L. Milesky, Coordinator of the West Central Regional Office of Mass. Medical Society



Gubernatorial Candidate, Steven Pierce

Mr. Pierce began by discussing the beginning of his campaign for governor. In this campaign he sees two fundamental problems in the leadership of Massachusetts. One is the fiscal problem whereby 10 to 12% annual increases in expenditures has been allowed to go on uncontrolled and secondly the credibility of people in Massachusetts government has reached an all time low with the citizens. A recent poll showed that 73% of the people in this state no longer believe what the elected officials tell them. The first order of business in any new government is to correct these two problems. As he sees it, the budget crisis is due to a legislature that has allowed the state's spending base to grow so during a period of record revenue growth that normal healthy growth cannot support that base, let alone new programs. We are not in a recession. Government revenues continue to expand at above 7%, but the increase in revenue spending exceeds the revenue growth. The current fiscal mismanagement is bound to have a negative effect on health care spending. The legislature has voted to reduce the funding of the phase in portion of the Universal Health Care Law. Medicaid funding has reached crisis proportions; the 15% state tax increase will go in large part to just pay the old Medicaid bills.

Apart from the budget crisis Representative Pierce recognizes that physicians in Massachusetts are caught between medical malpractice premiums and their inability to balance bill, leaving many physicians to retire or leave the state and that the relationship between the government and the entire medical community has grown more hostile. What can be done to turn this bleak situation around? First we must re-prioritize our spending and secondly we must consolidate and reorganize different parts of the government and thirdly we must create new sources of revenue. We must work on organizing long-term solutions to the Medicaid problem. Massachusetts has one of the most expensive Medicaid programs in the country. Medicaid takes up over one billion dollars of the state's 12 billion dollar budget. In order to improve access of quality care, doctors must be encouraged to leave their high concentration in the Boston and Worcester area and go out into other areas, such as Cape Cod and Franklin County. Finally, for the medical profession to thrive the government and the medical community must work together in making public policy and the government must stop over-spending and over-regulating.

A rather heated question and answer period followed. The first question concerned the Medical Malpractice Bill of 1986 which the questioning physician termed as inadequate and asked if Representative Pierce supported it. Representative Pierce said that he did support it, but not the caps on pain and suffering. He does not believe caps work well in other states. He believes that the JUA is taking serious steps toward stabilizing malpractice premiums and is keeping the raises to about 4.8% a year. This statement led an obstetrician in the audience to state that he believed that the JUA had misinformed Representative Pierce; that two years ago his medical malpractice premium was \$13,000, one year ago it was \$39,000, and now it is \$74,000. This is hardly a 4.8% raise. This physician went on to state that the caps on pain and suffering has helped medical malpractice

premiums in New York and California and he had a lot of problems hearing Representative Pierce talk against tort reform knowing that he is a lawyer and questioned whether he was representing the people he was elected to represent or was representing lawyers. He finished by stating that those who were familiar with Representative Pierce's voting record on tort reform and other medical issues must be suspect of where he would lead those issues if he were governor.

Representative Pierce responded by stating he represents 36,000 people which include doctors, lawyers, and a lot of other people. He recognizes that a civil justice system has to have some system that is fair in awarding some sort of monetary compensation for those injured and he just does not believe that tort reform is the answer to helping physicians in their malpractice problems. He went on to say that he approached tort reform as he approaches all other problems, that is to evaluate all the facts, listen to all the arguments and arrive at a decision. Representative Pierce thinks our real problems have more to do with over-regulation and the reimbursement policies.

The next question raised the issue of the growing drug problem and Representative Pierce expressed concern that in certain areas there are gangs and drug dealers who are rising up and taking over whole neighborhoods and confronting the police. He said that he feels we need much tougher sanctions against drug dealers and we need to return to the death penalty in this state, that we need improved drug education in the schools, especially in the early grades and he had a few words of praise for Governor Dukakis' efforts in this area.

Representative Pierce finished by saying that something has to be done about the balance billing problem. Perhaps a pilot program in a small segment of the state to try allowing balance billing might be a reasonable test. If elected governor next November, he would appoint several task forces to study problems between November and January and one of the first would be a task force on health care.

Terry D. Ryan, M.D.

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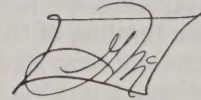
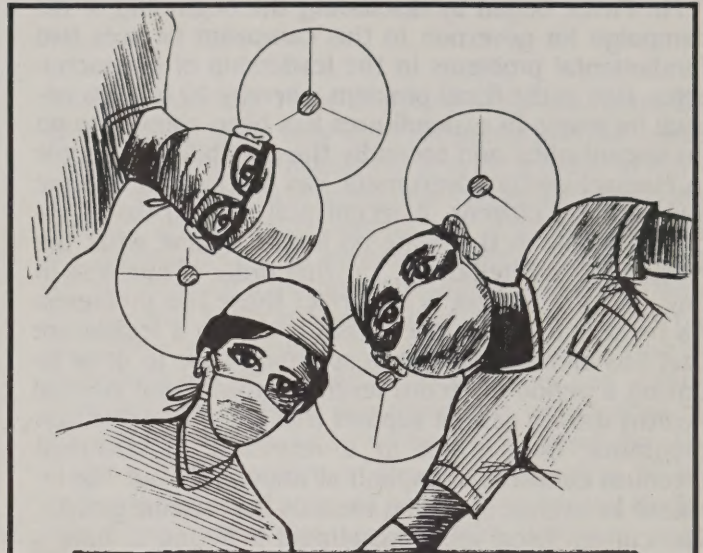
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Differing Views of our Health Care "Crisis"

The following are two articles concerning our health care "crisis" that have come across my desk in the past month. They are published because the contrasting points of view are quite remarkable. The physician's approach will be more recognizable to you. The business man's approach may shock you a bit, but I believe it is truly a common sentiment among business leaders.

Terry D. Ryan, M.D., Co-Editor

Health-care costs rise as technology advances

Health-care costs are out of control, and the politicians and the news media are rounding up the usual suspects; insurance conglomerates, avaricious doctors and hospitals that overbill. While this viewpoint may have its merits, perhaps it is time to address some obvious but ignored facts.

- All humans die. While theologians may wish to single out several exceptions, few would dispute this. Yet the constant clamor for reducing costs through preventive health care ignores this obvious fact.

Although many people are cognizant of the evils of cigarette smoking, fatty foods and obesity, they will eventually die. And before they die, some of them may become immobile from arthritis, and senile and incontinent from Alzheimer's disease. Thus, enormous medical costs will still be generated.

Those who dispute this have only to examine the recent behavior of corporate America, which is clamoring for government-backed universal health care. While this nascent altruism may represent a new frontier in corporate social awareness, one must also consider the possibility that several red-faced actuaries grossly underestimated the longevity and health-care costs of retirees, and thus would like to punt them to the government.

- The social structure of the city has deteriorated. Contrary to the message of the '60s, drugs and sex are not free and the bill is now due. Hospitals cannot pay high enough wages to attract nurses and technicians. Yet hospitals are expected to care for drug-addicted premature infants, substance abusers, AIDS patients and people with gunshot wounds who are covered by Medicaid. Government reimbursement does not come close to covering the expenses, and hospitals are thus forced to either close or pass them on to patients with insurance.

- The number of lawsuits will increase unless there is tort reform. Lawyers are fortunate in having the ability to create work for themselves. Thus, new theories to sack

public trusts are constantly being evolved. Since many doctor-patient interactions do not result in favorable outcomes, the number of lawsuits filed will continue to increase as long as the tort system remains a lottery.

Insurance companies, unable to predict the behavior of fickle juries, must maintain large reserves to meet their obligations. The public simply pays and pays and pays.

- The cost of health care will outpace inflation as long as technology continues to advance. Pundits who complain that health costs are rising faster than inflation neglect to mention that a pound of coffee 30 years ago is no different from a pound of coffee today. Health care is much improved.

Every two years, the life span of the average American increases by 16 weeks. Thirty years ago, if a patient had intractable chest pain, the patient simply suffered until he or she died. While it was unfortunate, at least it was cheap. Highly complex, expensive technology today not only relieves patients' suffering, but allows them to resume an active and productive life.

While the United States is one of the few industrialized countries that does not have universal health insurance, it attempts to distribute the latest technological advances to all citizens. In England, dialysis is refused to anyone over 55 unless they pay out of their own pocket. If an older person can't afford it, he or she simply dies.

No clear-cut solutions are on the horizon here in the United States. However, if Americans insist upon having the latest technological advances available to everyone, suing anyone for anything, and paying the health-care costs of irresponsible behavior, we can look forward to ever-increasing medical bills. If we insist on universal health insurance, the middle class will be denied the latest technological developments.

Joseph F. Bentivegna, M.D. is an ophthalmologist who practices in Rocky Hill CT.

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Doctor, Cure Thyself

The issues in the telephone workers' strike seem easy enough to understand. The workers insist that the company continue to pay 100% of the cost of their health insurance. The company insists on co-payment. The workers view it, doubtless correctly, as the thin end of the wedge, a small payment representing a small percentage of the health insurance cost, which will escalate to a big payment and a bigger percentage. The company counters that the cost of the health benefit is running out of control, and it simply can no longer shoulder the burden alone, the inflexibility of these two positions has led to cries to destroy telephone bills, to the demise of directory assistance, and increasing difficulties for telephone customers.

In the heat of the strike, nobody is focusing on the real villain, which is the health industry. Ever-escalating health costs are treated, for the purpose of the argument, as a given. That's probably just what the doctor ordered. But in fact, the problem is never going to be solved until it is attacked at the root, which is simple enough: the greed of the medics. Arbitrageurs, buyout artists, greenmailers and the like seem reasonable and gentle folk compared to the rapacious doctors.

One day in August, my three daughters visited the dentist. This was normal enough stuff: checkup (no problems), x-rays (nothing unusual), and a little lecture on how and how often to brush their teeth. Within 90 minutes the invasion was over. The bill came to \$454. You can, of course, argue that this tallies up only to \$302 per hour, and after all, the education, the insurance, the overhead... blah blah blah, whine whine whine.

The fact is, of course, that 90 minutes in a dentist's office, mostly being attended by paraprofessionals, is not worth \$454. It is not worth \$454 the same way the Stealth bomber is not worth \$500 million, the same way that your generic lawyer is not worth the powder to blow him to hell—no, I take that back: the powder might be a very good investment.

I am aware that this sounds like a very simplistic argument, that people will argue that modern medical technology is wonderful, and by definition is wonderfully expensive. That our society has not been able to deal with the problem of what to do when it is frequently possible to keep people alive for very long periods of time, provided that the money's there to prolong the life. We are aware that the cost of medical malpractice insurance is high, and that talented lawyers are able to find patients who would like to sting the doctors back.

But the *root* of the problem is the greed of the doctors. When I was a lad, doctors were pillars of the community, would go out at night to treat sick people, and charged the kind of money their patients could afford. A lot of them got stiffed, we heard, and took that as part of the territory. To *sue* a doctor in those times was an antisocial act. The accepted ethic was: *The doctor is doing the best he can, and if you don't like it, go doctor with someone else.* A few people did, indeed,

continued

"doctor around," but most accepted sickness as something natural, like rain.

Now the doctor is a pillar of the country club, and that's it. Over a few decades of escalating greed, the customers have turned churlish, and when the lawyers call for testimony, the pews fill up. The doctors brought the medical malpractice "crisis" upon themselves. Their exaggerated expectations of profits dragged the rest of the structure behind, until by now it's so heavy it's likely to topple. The worst instinct is to throw in the sponge, to toss the whole rotten mass into a government entitlement, where the hoggish practices could endure forever. The better standard would be for the customers—whether the billpayers are insurers or companies or individuals—to determine the real value of a dental check-up, the real cost of setting a broken arm or curing a case of the sniffles. Then pay that much and no more.

This would not be popular in some quarters. We hear that Massachusetts has been so unhospitable to the medical profession that we are threatened with a crisis of supply. It's to laugh. To watch greedheads who pull out is like watching lawyers locked in mortal combat; whatever the outcome, society wins.

Indeed, paying the true value of medical care would probably drive some practitioners out. Some might look at the structure and opt for a mid-career correction—into stockbroking, or law. Oh well, they will become a problem for another day.

But we think the union and the phone company should be able to get together. They don't have to rip up their phone bills—just tear up the doctors' bills. ■

"Reprinted with permission of the New England Business magazine and the Editor, Kenneth Hooker."

Mr. Richard A. Bird
New England Business
33 Union Street
Boston, MA 02108

October 5, 1989

Dear Mr. Bird:

Mr. Kenneth Hooker, in his recent *Comment*, blamed doctors for the current telephone workers' strike. His "simplistic argument", his own words, is that "the greed of the doctors" makes medical bills high. This is not only simplistic, it is incorrect. Patient expectations make medical bills high. Patients expect, and rightly so, to have both first class care available 24 hours a day and to be able to sue for redress if that care does not meet their expectations. This makes hospitalization, malpractice insurance and health insurance very expensive. Mr. Hooker's analysis is glib and and insulting and his solution—"tear up the doctors' bills" in no way deals with the real issues of the telephone strike.

Sincerely,

Nancy L. Weiss, M.D., President
Hampden District Medical Society

Springfield Public Health Department Upgrade Report

The dire consequences resulting from the layoffs of the 57 staff members of the Springfield Public Health Department (SPHD) has been felt mostly by the elderly and the dental services to the children without third party reimbursement payment ability.

The entire dental unit, including the fluoride mouth-rinse program of the 11,000 first to sixth grade students has been eliminated. Gone is the homebound dental program which provided bedside care to the elderly confined to their homes by use of a portable dental unit, and, also, the screening of elderly patients in senior housing centers. However, the dental care program for prisoners and HIV carriers was salvaged. The County Sheriff's office contacted the dentist and STCC students of the dental hygiene school for their services. The SPHD provides that unit with the portable equipment to service the prisoners.

Another success has been the increase of our Homeless grant by an additional \$150,000, which allowed the SPHD to provide additional staff to the Mercy Hospital and Sisters of Providence and Friends of the Homeless units. This has assured that care and treatment of homeless families, especially children living in motels and shelters throughout the Greater Springfield area will be served throughout the winter.

Our Sexually Transmitted Disease program—totally supported by the State was left untouched.

The programs lost were all of those provided by the

professional staff of the SMITH Center—the Hypertension, Wellness, Nutrition, Bi-lingual Consultation, Dental Screening, Vision & Hearing Testing of the elderly and Health Education counselling in pre- and post natal care. Those programs were staffed by professional nurses, dental hygienists, dentists and others, who did not have Civil Service status and were considered Provisional as a consequence of tests not being offered by the Civil Service Commission in those professions. The order of layoffs was for all provisional or temporary staff to be let go before permanent civil service members. The result was our most professionally qualified staff was eliminated.

Other victims were the sanitarians—all but one were Provisional. There are only two remaining sanitarians for the City. To meet our quota of the budget, an additional 5 nurses were laid off and 8 demotions were made.

Currently, the SPHD is engaged in seeking funds and assistance through grants. We are approaching local, State, Federal and Philanthropic Agencies for funding.

Our once proud health department which boasted 118 members and was second only to Boston in services rendered, has been reduced to a skeletal structure of its former self. To the best of our ability, we shall do our best to protect the health of Springfield's citizens.

John J. Cipolla
Commissioner of Public Health
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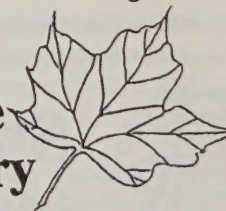
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2 Medical Center Drive
Suite 404
Springfield, MA 01107

BORN: June 9, 1957
PREMED: Brown University Rhode Island
1975-1979
MEDICAL: Vanderbilt University Affiliated
Hospitals, Tennessee 1979-1983
INTERNSHIP: Vanderbilt University Affiliated
Hospitals 1983-1985 and 1986-1987
RESIDENCY: Baystate Medical Center 1987-1989
FELLOWSHIP: University of Melbourne, Australia
1985-1986
SPECIALTY: General Surgery

Philip T. Glynn, M.D.
163 Silver Street
Agawam, MA 01001

BORN: December 9, 1951
PREMED: Boston College 1970-1974 and
Columbia University 1974-1975
MEDICAL: University of Rome 1979-1984
University of Sassari 1978-1979
INTERNSHIP: St. Raphael Hospital, Connecticut
1984-1985
RESIDENCY: St. Raphael Hospital, Connecticut
1985-1987
FELLOWSHIP: Baystate Medical Center 1987-6/89
SPECIALTY: Internal Medicine/Oncology

Jeffrey F. Joseph, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN: February 17, 1961
PREMED: University of Rhode Island 1979-1983
Georgetown University 1984-1985
MEDICAL: New York Medical College 1985-1989
INTERNSHIP: Baystate Medical Center 7/89
SPECIALTY: Obstetrics/Gynecology
RESIDENT

Andrew G. Moskovitz, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN: October 24, 1963
PREMED: Syracuse University 1981-1985
MEDICAL: State University of New York Health
Science Center 1985-1989
INTERNSHIP: Baystate Medical Center 7/89
SPECIALTY: Internal Medicine/Pediatrics
RESIDENT

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Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN: November 2, 1960
PREMED: University of Vermont 1978-1979 and
Brandeis University 1979-1982
MEDICAL: New York Medical College 1984-1988
INTERNSHIP: Jersey Shore Medical Center, New
Jersey 1988-6/89
RESIDENCY: Baystate Medical Center 7/89-
SPECIALTY: Radiology
RESIDENT

Joan A. VanSloun, M.D.

Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN: February 16, 1959
PREMED: Marquette University, Wisconsin
1979-1985
MEDICAL: Medical College of Wisconsin 1985-1989
INTERNSHIP: Baystate Medical Center 7/89
SPECIALTY: Anesthesiology
RESIDENT

Peter Whittredge, M.D.

444 Montgomery Street
Chicopee, MA 01020

BORN: December 6, 1948
PREMED: Tufts 1966-1970
MEDICAL: S.U.N.Y. at Buffalo 1970-1974
INTERNSHIP: Boston City Hospital 1974-1975
RESIDENCY: Boston City Hospital 1975-1976
FELLOWSHIP: Tufts-New England Medical Center
1977-1979
SPECIALTY: Internal Medicine / Cardiology

Joseph E. Flack, III, M.D.

Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN: April 25, 1954
PREMED: Pennsylvania State University
1972-1976
MEDICAL: New York Medical College 1976-1980
INTERNSHIP: West Virginia University Medical Center
1980-1981
RESIDENCY: West Virginia University Medical Center
1981-1985
University of Miami, Jackson Memorial
Hospital 1985-1987
FELLOWSHIP: Surgery Branch, NHLBI of NIH,
Bethesda, Maryland 1987-1989
SPECIALTY: Cardiothoracic Surgery

Leonard H. Shaker, M.D.

2 Medical Center Drive
Suite 301
Springfield, MA 01107

BORN: April 16, 1957
PREMED: Brandeis University, MA 1975-1979
MEDICAL: University of Vermont College of Medicine
1980-1984
INTERNSHIP: St. Louis University, Missouri 1984-1989
RESIDENCY: St. Louis University, Missouri 1984-1989
SPECIALTY: Urology

Sanjeev Sabharwal, M.D.

Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN: August 6, 1961
PREMED: Modern School, Delhi, India 1977-1979
MEDICAL: University of Delhi, India 1981-1985
INTERNSHIP: St. Elizabeth's Hospital, Ohio 1986-1987
RESIDENCY: St. Elizabeth's Hospital, Ohio 1987-1988
FELLOWSHIP: Boston City Hospital 1988-6/89
Baystate Medical Center 7/89-Present
SPECIALTY: Orthopedic Surgery
RESIDENT

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Hampden District Medical Society Auxiliary Update

The HDMS Auxiliary has begun another year under the direction of a Presidium with positions filled as follows: Lynn Papale, Secretary; Ann Zumwalt Coppola, Treasurer; Patricia Tinervia, Health Education Chairperson; Robin Wagner, Social Chairperson; Joan Hampf, Scholarship Program Chairperson and Diane Goodman, Scholarship Program Treasurer.

The goals of the organization remain the same:

- to help the HDMS whenever possible;
- to offer social events which give medical spouses the opportunity to meet;
- to participate in health related projects which benefit the community; and
- to become informed on health related legislative issues.

This year we have undertaken an extensive campaign to increase our membership. The Presidium also decided that, beginning this year, the Auxiliary should adopt an annual project to which we can offer both our time and some financial support. The Ronald MacDonald House, being built in Springfield, has been selected for

1989-1990 and the national Bone Marrow Donor Foundation will be our project for 1990-1991.

The Auxiliary is sponsoring a Christmas/Holiday card sale with all profits being donated to the Ronald MacDonald House. Anyone interested in ordering personalized cards through the Auxiliary should contact Diane Goodman at 567-3163 between September 15th and December 5th.

The Auxiliary's fall social will be a breakfast on Thursday, November 9th at the home of Debra Calvanese in Longmeadow. The selection of Christmas/Holiday cards on sale through the Auxiliary will be on display at this breakfast.

Last June, the Auxiliary Scholarship Program, managed by Joan Hampf and Diane Goodman, awarded six \$500 scholarships from the donations raised during the 1988-1989 campaign. Four of the recipients are nursing students, one is studying pharmacy and one is in a physical therapy program. This year's scholarship drive will begin at the end of October.

Anyone interested in joining the Auxiliary should contact a member of the Presidium.

Lynn Papale



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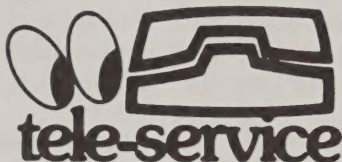
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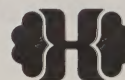
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Welcome Kerin Milesky

As you have probably heard, Mass. Medical Society has decided to open a Western Massachusetts office in Northampton at 98 Main Street. We would like to take this opportunity to introduce to you and to welcome Kerin Schweiger Milesky who has been named the Director of this MMS Extension Office which opened in early October. I am sure you will be receiving communications from Kerin and MMS as to her goals, phone number, etc.



Kerin Schweiger Milesky,
Coordinator Western Central
Region, Mass. Medical Society

Mrs. Milesky is a graduate of the University of Rhode Island where she had a major in Public Health Education. Her career has brought her experience in the University of Rhode Island Annual Fund Office, as Health Educator for the Town of Teaneck where she wrote a weekly health column in a local paper, to more recently working for the American Cancer Society first as a Director and then as an Area Director where she managed the local office, coordinated special events and was responsible for managing public education programs.

We look forward to working with Mrs. Milesky and have offered her space in the Hippocrat whenever she desires it. ■

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Great respect is due this mature gentlemanly physician for his loyalty and dedication to his home state, to Maine, to Amherst College, and to Ludwig von Beethoven. ■

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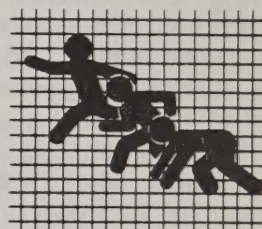
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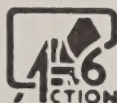
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